BOSTON UNIVERSITY

SCHOOL OF SOCIAL WORK

A STUDY OF INTAKE AT THE WEST END CHILD GUIDANCE CLINIC FOR THE FISCAL YEAR 1946 (JULY 1, 1945 - JUNE 30, 1946)

A Thesis

Submitted by

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(B. A., Brooklyn College, 1945)

In Partial Fulfillment of Requirements

for the Degree of Master of Science in

Social Service

1947

School of Social Work
May 28, 1947
1662

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

INDEX OF TABLES

INDEX OF TABLES

INDEX OF FIGURES

INDEX OF FIGURES

CHAPTER I

INTRODUCTION

PURPOSE, METHOD AND SCOPE

This thesis is to be a study of the Intake at the West End Child Guidance Clinic during the fiscal year 1946 (July 1, 1945 - June 30, 1946).

Intake was selected as a point of inquiry to determine the extent to which the function and services of the clinic are utilized by the agencies and the individuals of the community. Questions relating to the nature and types of service rendered, to whom, to fulfill what needs and for what kind of patients, will be some of the areas of focus of this work. It is hoped that from this survey an understanding of the clinic's status in the community will be attained.

In order to understand the present day function of the Child Guidance Clinic, the writer will trace the development of the Child Guidance Movement and the present day philosophy of Child Guidance.

The latter part of the thesis will be devoted to a statistical study of the seventy-three new cases which received services at the West End Child Guidance Clinic during the period in question. To point out the all-important

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human elements which are an integral part of Child Guidance and to clarify the clinic's services in terms of actual practice, as well as in terms of the statistical analysis, three brief case illustrations will be presented.

The year beginning July 1, 1945 and ending with June 30, 1946 has been chosen because it is convenient from two points of view. First of all, the statistics and records for this period are available in the agency. Secondly, this year appeared to be a representative period in which to do the study because it is close enough to the present to give a true picture of the agency today and, at the same time, sufficiently in the past to lend itself to study.

In this survey, only the seventy-three new cases which were active with the clinic during the year have been considered. The twelve re-opened cases which, if added to the seventy-three new cases, would make the total intake eighty-five, were excluded because it was felt that the addition of these cases would invalidate the study. The writer feels justified in using only the new cases because the factors which bring the client, whose case has been closed, back to clinic for further service, cannot be scientifically classified and analyzed with the factors which enter into the introduction of the "new" client.

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The data herein contained has been taken from the record of each case represented in the study. Each case record consists of a psychological report, a psychiatric record, and social service notes.

In order to avoid any subjective interpretation of terminology employed, all terms which might lend themselves to misinterpretation have been defined. It is felt that the ultimate conclusiveness of the material presented in this work is affected by the relatively small number of cases studied. All that may be said in reference to most of the data discussed is, this was found to be true at the West End Clinic during 1946 and there is no indication of its not being true in the future.

The stated[1] program of the West End Child Guidance Clinic is:

> " .... prevention of difficulties arising from some of the simple traits of early childhood."

Its stated service is:

> " .... the study and treatment of children by a specially trained group of experts, including a psychiatrist, psychologist, and psychiatric social worker."

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CHAPTER II

HISTORICAL DEVELOPMENT

OF CHILD GUIDANCE

In order to understand the Child Guidance Clinic and the service it renders, it is of importance to realize how it emerged as a result of the converging of interest stimulated earlier in two allied but distinctly separate areas - that of Mental Hygiene and Juvenile Delinquency.

These two fields, whose evolution were almost parallel, follow the same general trend of development. Focus in these areas followed the pattern of segregation and degradation, to rehabilitation to prevention.

Mental Hygiene as a formal movement is less than forty years old. Clifford Beers who, because of his own experiences as a victim of mental breakdown, gave rise to the movement by publishing, after his recovery, "A Mind that Found Itself." In this vividly written volume, Beers told of his life as a patient who, for a period of three years, had been in several mental institutions.

Determined to do something about the deplorable lack of understanding and sympathy for the mentally disturbed, Beers with dogged persistence waged a one-man fight to

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attract public attention to the conditions existing in mental hospitals and to the treatment afforded to the patients in these hospitals. Beers finally enlisted the support of William James, the psychologist, and Adolph Meyer, the distinguished psychiatrist who had for some time been pursuing scientific investigation into the need for improving the status and treatment of the mentally ill.

In 1908, through the combined efforts of these men, the Mental Hygiene Movement was formally established; its purpose was to change the attitude of the public toward mental patients from that of a "punitive" or "mad dog" one to an attitude of understanding, sympathy and tolerance.

The aforementioned purpose proved to be no small task, for the Mental Hygienists were faced with changing attitudes which had been firmly planted in the distant past when superstition and demonology permeated all attempts to understand non-conforming behavior and actions.

In pre-medieval time, persons who suffered mental illness were regarded as being possessed of a demon or an avenging deity. The type of therapy used in those days was torture and exorcism. To torture a person who was disturbed was to torture the devil which possessed him; with ritual and ceremony the "evil spirit" was to be driven away.

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In medieval times, the mentally ill were regarded as being punished for a sin or as being in league with Satan. Since the person displaying symptoms of disturbance personified Mephistopheles and, since Mephistopheles had to be disposed of, the mentally ill, as their cavemen brethren before them, were tortured or punished with a great display of religious fervor.

The preceding attitudes were passed on from century to century so that, even in Colonial times, it is recorded that disturbed persons suffered torture and brutality at the hands of their neighbors because persons with nonconforming behavior were thought to be practicing witchcraft.

Therefore, when the supporters of the Mental Hygiene Unit set out to educate the public, - to remove superstition and in its place to nurture the realization that mental disturbance is an illness and not a demonic invasion, - they undertook a Herculean task. However, since much research had been going on in the area of psychological processes, it did not prove impossible to gain the backing of enough persons to make the Mental Hygiene Movement an effective one. Gradually more people began to realize that mental disease, like physical disease, is a misfortune and not a disgrace and the Mental Hygiene Movement received sufficient support in professional circles to maintain itself and to attempt to expand its influence.

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Once begun, the movement gained momentum. The first Society for Mental Hygiene was founded on May 6, 1908 in Connecticut. By 1909 a National Committee for Mental Hygiene was established and, within a decade, the International Committee for Mental Hygiene was organized.

In 1909, while Beers and Meyer were busy organizing the National Committee for Mental Hygiene, Dr. William Healy who for some time had been interested in the juvenile offender, founded the Chicago Juvenile Psychopathic Institute. His purpose was to study the delinquents in the Chicago area. His work with youthful offenders attracted the intellectual curiosity of the judges in the vicinity. In 1917, with funds provided for by the friends of Judge Harvey Baker who in 1915 drew up a statement urging a clinic similar to the Chicago one, the Judge Baker Foundation was established in Boston. Dr. Healy was called from Chicago to direct it.[1]

In 1920, the National Committee for Mental Hygiene, which had by this time established a Division on the Prevention of Delinquency, aided by the finances of the Commonwealth Fund, set up a plan for experimental demonstration clinics throughout the country. Its experimental program had four stated aims:

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1 George S. Stevenson and Geddes Smith, Child Guidance Clinics; A Quarter Century of Development (New York: The Commonwealth Fund, 1934) p. 15.

1. To develop the psychiatric study of difficult and delinquent children, and to develop sound methods of treatment based on such study.

2. To develop the work of visiting teachers, whereby the invaluable early contacts that our school system makes possible to every child, may be utilized for the understanding and development for the child.

3. To provide courses of training - for those qualified to enter this field.

4. To extend by various educational efforts the knowledge and use of these methods.[2]

In conjunction with the tentative program, the New York School of Social Work instituted courses and provided fellowships for training in the field as well as for establishing a psychiatric clinic for the study and treatment of children's problems in order to secure field training for its students.

Thus, by 1922 the National Committee for Mental Hygiene aided by the Commonwealth fund, had co-ordinated the highly specialized skills of psychiatry, psychology and social work to form a working child guidance clinic.

The first of these demonstration clinics, situated in St. Louis, started operation in 1922. The success of

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this demonstration clinic became nationally known and led to the organization of similar clinics in other cities throughout the United States.

In 1927, after five years' experimental work in the demonstration clinics, professional focus began to shift from delinquency and the court to the more subtle evidences of non-adjustment in the home and school. Much had been learned about the co-functioning of the clinic and other social agencies in the community. Trial and Error experience with finances and personnel pointed out many problems to be overcome but, at the same time, had given the experimenters sufficient opportunity to observe the service in operation and to glean from these observations not only the problems which, in the future, had to be met, but also the subtle manifestations of the most fruitful area of "work with children." Out of the more or less "hit and miss" attempts had come an abundance of awareness from which emerged much of the recognition for the apparent need for a service similar to that rendered by the Child Guidance Clinic of today.

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or schools, and referrals came from teachers, social workers, and finally from the parents themselves.[3] In the last analysis the agencies which had primarily hoped to show "the juvenile courts and child caring agencies what psychology and social work had to offer in connection with the delinquent child"[4] and who had directed their psychiatric and socio-cultural attack on delinquency, realized that the most effective meliorative and preventive work lay in treating those children whose difficulties had not yet caused their court appearances. Herein was born and nurtured the philosophy of present-day child guidance.

The Development of State Supported Child Guidance Clinics

The first state to provide for the establishment of state-financed Child Guidance Clinics was Massachusetts. In 1922 the state legislature provided for a division of mental hygiene which would have Child Guidance as one of its activities.[5]

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3 Helen Witmer, Psychiatric Clinics for Children, (New York: The Commonwealth Fund, 1940) pp. 51-52.

4 Lawson Lowry, "The Child Guidance Clinic," Childhood Education, Vol. I (1924) p. 100.

5 Acts of 1922, Chapter 519.

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3 Helen Witmer, Psychiatric Clinics for Children, (New York: The Commonwealth Fund, 1940) pp. 81-82.

4 Lawson Lowry, "The Child Guidance Clinic," Childhood Education, Vol. I (1924) p. 100.

5 Acts of 1922, Chapter 519.

Prior to this enactment, Massachusetts had been interested in the Mental Hygiene Movement. Through legislation in 1919 it became compulsory to have all children who were three or more years retarded examined.[6] To carry out this act. the State hospitals instituted Traveling Clinics. At this time, too, the Massachusetts State School for the Feeble-Minded was established.

Once started in its mental hygiene program, the state of Massachusetts expanded its services in this area. By 1920 a number of out-patient mental hygiene clinics were rendering services to adults and children. It was at this time that the Boston Psychopathic Hospital was established as an independent unit for screening committable cases and furnishing treatment for milder forms of mental illness. The latter service was in immediate demand and was faced with problems from infancy to adulthood.[7]

When, in 1921, Dr. Douglas A. Thom was asked by the Baby Hygiene Association of Boston, to make a survey of one of the health clinics in order to determine whether a psychiatrist would have something to contribute to the Clinic's program of preventive medicine, another step

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6 Acts of 1919, Chapter 277.

7 Edgar Yerbury, C and Nancy Newell, The Development of the State Child Guidance Clinics in Massachusetts. Massachusetts Department of Mental Health (1945) p. 23.

forward in the Child Guidance Movement was about to be taken. Dr. Thom, though he entered into the survey with much misgiving about the treatment possibilities of children, became immediately aware of the vast source of promising psychiatric treatment possibilities in the very young. In a very short time, with Dr. Thom as director, three clinics for young children were established by the Community Health Association. These clinics which specialized in psychiatric therapy for young children were called "habit clinics."

In 1922, when the state legislature provided for a Divison of Mental Hygiene, Dr. Thom became director of encompassing state program for promoting mental health. As director of the Division of Mental Hygiene, Dr. Thom carried over his enthusiasm for Child Guidance into the state program. In 1923, Boston boasted three state-financed and operated Child Guidance Clinics. As the years passed, and with the impetus provided by the Massachusetts Society for Mental Hygiene, clinics were projected into other communities throughout the state.

Today, Child Guidance has reached its maturity. It has emerged as a smooth-working, efficient organization, within which the psychiatrist, psychologist and social worker function co-operatively in diagnosis and treatment adapting the intensity and quantity of their services to

the individual case referred. The Clinic is recognized as offering an invaluable service to mankind - a service which endeavors to assist our youth to develop their capacities to the fullest by reducing those pressures, strains and involvements which would tend to block the full fruition of these potentialities.

I

CHAPTER III

THE WEST END CHILD GUIDANCE CLINIC:

ITS STRUCTURE, ITS SERVICES

a. The Clinic in Operation

The West End Child Guidance Clinic is one of the oldest state-supervised clinics in Massachusetts. It has been in operation since 1924.

The clinic is in session Wednesday afternoons at the West End Health Unit on Blossom Street in Boston.

As in most Child Guidance Clinics, both public and private, the basic unit of the clinic staff is the psychiatrist, the psychologist and the social worker. However, the staff of, and services rendered by, the West End Clinic are enhanced by a Speech Therapist and a Remedial Reading Tutor. Not all clinics have the latter two on their staff.

The intake policy of the West End Clinic provides for the acceptance of all cases without regard for race, religion, or social and economic status.[1]

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1 Since the Clinic is a tax-supported agency, there is no question of fees.

The only factors which enter into the accepting of a referral are age[2] and suitability of the presenting problem to the services rendered by the clinic.

This last criterion is justified by the fact that the clinic's staff resources and services cannot possibly fulfill all the demands for service which it receives; therefore, in order to render the most good to the greatest number, problems to which the function of the clinic can be most constructively applied are the ones which are selected for service. In instances when other agencies in the community are more adequately equipped to answer a specific request, the referring agent is "steered" to that resource. For instance, in cases where feeble-mindedness is apparent, the clinic refers the applicant to the Division of Mental Deficiency.

The Intake Procedure

Children are referred to Clinic because of maladjustment either at home or at school due to undesirable habits, personality deviations, or perhaps inadequate intellectual equipment.

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In most instances, the social worker is contacted by the referring agent either by phone, mail, or if the referral is a personal one, by the parent himself. The social worker schedules an appointment at a time convenient for the client and practical for the clinic. At present, the interval between the initial referral contact and the intake interview at clinic may be several weeks.

When the patient, who is usually accompanied by parent or parent substitute, appears at clinic for his first interview, he is greeted by the social worker. To put him at ease, and to keep him diverted while waiting his turn, as well as to observe his reactions at clinic, play equipment is provided for the child's use.

While the child busies himself, a social worker interviews the adult and obtains a general description of the child, his problem, the precipitating factors culminating in his referral to clinic, and other similar information which might prove helpful to the clinic staff in their contacts with the child.

While the social worker is completing the interview and has familiarized the informant with the clinic set-up, the child is prepared for his interview with the psychologist. While the child receives his psychological tests, the adult has an interview with the psychiatrist. The psychiatrist

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and the adult discuss the child's problem further. After the child has received his psychological test he too is interviewed by the psychiatrist. In this manner, aided by the work of the psychologist and the social worker, the psychiatrist obtains sufficient data upon which to formulate a tentative recommendation for service. If speech training or remedial reading is indicated by the psychological results or by the clinical picture presented by the client, he is referred by the psychiatrist to the speech therapist or tutor respectively.

At this point, it may be well to indicate that in general the clinic classifies its services in terms of "diagnostic" or "treatment" service.

Diagnostic service is a service in which the child and his situation are studied in whole or in part for psychological and/or psychiatric evaluation and solution of the problem, but where the clinic has no active part in the subsequent progress of the case. In other words, after the diagnosis has been made, recommendations for immediate steps in treatment are formulated. However, the responsibility for the carrying out of the recommendations for treatment is carried out by the referring agent. This service is available to agencies and individuals in the community.

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Treatment service is service which, in addition to diagnostic service, consecutive contacts are made with parent, child or other persons by the clinic staff for the purpose of influencing the progress of the case.

Treatment, as such, is hard to define because its scope, intensity, and quantity varies with the psychiatrist's recommendations in each individual case.

Helen Witmer states:

> "A survey of current practices reveals four general types. In the first place, much of the work of many clinic centers around attempting to make the environment an easier or pleasanter place for the patient to live in. This may take the form of providing a new environment for him or attempting to remodel the old one. Included in this method are such diverse activities as those aimed at modifying parents' attitudes or relieving their tension and those of "interpreting" the child to his teachers and other adults, various other kinds of modification of the school environment, foster home, or institutional placement, and the like. Directed toward the patient rather than toward the environment is the approach that attempts to find new outlets for the patient's energies or capacities - the building up of new recreational interests, the fostering of undeveloped talents, the encouragement of activities in which he is likely to find success. A third approach consists of remedying the patient's specific disabilities - physical and intellectual; that is, removing certain specific internal obstacles so that he is put more on par with his fellows. Finally, treatment may consist of a direct dealing with his psychic problems.[3]..."

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As stated before, at the West End Clinic treatment varies with the needs presented by each case. However, the clinic in general uses a combination of these four approaches.

Thus it is indicated that the study and treatment of problems referred to a Child Guidance Clinic involve certain social, psychological and psychiatric techniques. These techniques are refined by the previously outlined clinical procedure. At the West End Clinic, no rigid treatment procedure is carried out. No one school of thought is adhered to and treatment varies individually with the patients.

b. Operation Statistics for Year 1946.

In 1946, the clinic held forty-six sessions.[4] During this period, 814 visits to clinic were made by the clinic patients. This makes an average of 17.7 visits per session and an average of 5.9 visits per child served. In considering the last two figures cited, we must keep in mind that these are statistical averages and that some children make more visits to clinic than these averages imply, while others attend clinic less frequently.

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4 Clinic is closed for vacation during the month of August.

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4 Clinic is closed for vacation during the month of August.

In the following table it is indicated that the clinic served one hundred and thirty-eight cases. Of these, sixty-five were old cases. Of the seventy-three new cases served during the year, twenty-four were given diagnostic service and the remaining forty-nine cases received treatment service of some kind.[5]

TABLE I

WEST END CLINIC ATTENDANCE FOR FISCAL YEAR 1946

No. of Clinic Sessions	46	
No. of Visits to Clinic by Children	814	
Av. No. of Visits per Session		17.7
Av. No. of Visits per Child Served		5.9
Total No. of Cases Served	138	
1. Total Old Cases	65	
2. Total New Cases	73	
a. Diagnostic 24		
b. Treatment 48		
Av. Case Load per Month		65
Total No. of Cases Closed (Old and New)	85	
1. Total Diagnostic	36	
2. Total Treatment	49	
Condition on Closing (Old and New)		
1. Diagnostic Service Rendered	36	
2. Treatment Rendered	49	
a. Improved	29	
b. Unimproved	10	
c. Unknown	10	
d. Transferred to Other Agency	0	
Cases Carried Over to Following Year	53	

5 The remainder of the statistics in Table I are self-explanatory. Therefore it is felt that no further discussion of them is necessary.

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Table II indicates that of the seventy-three new cases, thirty-eight were closed by the end of the fiscal year. Of these, twenty-four of the cases closed received diagnostic service. Fourteen of the new cases which were closed during the year were treatment cases. Nine of the treatment cases, or 64.29%, had shown improvement at the time of closing, 21.43% had shown no improvement, and in two cases, or 14.29%, condition at time of closing was unknown. Thirty-five of the new treatment cases were carried over to the following year.

TABLE II

NEW CASES AT WEST END CLINIC WHICH WERE OPENED AND CLOSED DURING FISCAL YEAR 1946

Cases Opened and Closed	No.	
1. Total New Cases Closed	38	
1. Diagnostic Service	24	
2. Treatment Service	14	
a. Treatment improved		9
b. Treatment unimproved		3
c. Treatment unknown		2
2. Cases Carried Over to Next Year	35	
TOTAL	73	

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TABLE III

INTERVIEWS HELD IN CONNECTION WITH WEST END CLINIC CASES DURING FISCAL YEAR 1946 (JULY 1, 1945 - JUNE 30, 1946)

Interviews	No.	Total
I - Social Service - In Community		331
Home	126	
School	52	
Others	137	
Conference	16	
II - Clinic		1573
a. Psychiatrist	354	
b. Psychologist	113	
c. Social Worker	235	
d. Speech Worker	763	
e. Tutor	108	
III - Office[6]		964
a. Telephone	557	
b. Interview	55	
c. Consultation	352	
GRAND TOTAL		2368

6 Interviews held by all members of the clinic staff.

TABLE III

INTERVIEWS HELD IN CONNECTION WITH WEST END CLINIC CASES

DURING FISCAL YEAR 1946 (JULY 1, 1945 - JUNE 30, 1946)

Interviews	No.	Total
I - Social Service - In Community		831
Home	186	
School	32	
Others	137	
Conference	16	
II - Clinic		1873
a. Psychiatrist	354	
b. Psychologist	113	
c. Social Worker	338	
d. Speech Worker	763	
e. Tutor	108	
III - Office[6]		964
a. Telephone	837	
b. Interview	55	
c. Consultation	352	
GRAND TOTAL		3668

6 Interviews held by all members of the clinic staff.

In Table III the number of interviews held by members of the clinic staff, in connection with the cases served, are indicated. From this table some understanding of the social worker's part in the treatment activity may be determined. Whereas the other members of the clinic staff confine their contacts with the patient to the clinic situation, the social worker serves as the intermediary between the clinic and the patient in his social constellation. Whereas two hundred and thirty-five social service interviews were held at the clinic, three hundred and thirty-one additional social service interviews were conducted in the home, in the school, in other agencies, or in conferences.

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CHAPTER IV

THE CLINIC AND THE COMMUNITY

Having made a preliminary survey of the West End Child Guidance Clinic, and having gained some insight into its purpose, structure, and function, we are now ready to consider what its role is in the community.

It is hoped that some understanding of the status of the clinic may be obtained through:

1. An analysis of the extent to which the clinic serves the areas it purports to serve.

2. An analysis of the sources from which the clinic patients are referred.

Before discussing the clinic and its relationship to the community, the author would like to clarify her use of this term.

In this thesis, the term "Community" does not refer to the immediate locale within which the clinic is situated. "Community" as applied throughout this discussion means the general area surrounding and including the Corporate City of Boston. The justification for this definition lies in the fact that in The Child Guidance Clinics, Their Purpose and Function[1], the question of "who may use the Child

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Guidance Clinics?" is answered with:

> "Any agency or individual in any part of Massachusetts may bring or refer a child for study and treatment, provided that his home is near enough to make a study of his environment possible."

In general, because there are several other state Child Guidance Clinics situated strategically throughout Massachusetts, it is found that in terms of accessibility the clinic's area of service sets its natural limits. For the most part, besides serving the Corporate City of Boston, the clinic serves the areas referred to as the Northern Area of Greater Boston.

Table IV indicates the extent to which the West End Clinic serves the cities and towns which lie within visiting distance of it.

The table indicates that the clinic serves nineteen cities and towns outside the limits of the Corporate City of Boston. Of the seventy-three cases studied, forty-two patients, or 57.53% of the total number studied come from areas outside the city of Boston. Thirty-one patients, that is, 42.47% of the new cases are children who live in Boston.

Although in some instances the clinic's contact with community is only in respect to one case, the relationship is not to be considered lightly. It is recognized that each time the clinic expands its area of influence, an

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TABLE IV

COMMUNITIES IN WHICH NEW CASES OPENED

DURING FISCAL YEAR 1946

Place		No. of Referrals	%
1. Boston (Corporate City of)	(Total) 31		42.47
2. Metropolitan Area	(Total) 42		57.53
	Everett	7	
	Chelsea	5	
	Malden	5	
	Medford	3	
	Walpole	3	
	Norwood	3	
	Cambridge	2	
	Waltham	2	
	Winthrop	2	
	Billerica	1	
	Brookline	1	
	Framingham	1	
	Maynard	1	
	Melrose	1	
	Milton	1	
	Natick	1	
	Saugus	1	
	Somerville	1	
	Watertown	1	
GRAND TOTAL	73		100

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	Medford	3	
	Walpole	3	
	Norwood	3	
	Cambridge	2	
	Waltham	2	
	Winthrop	2	
	Billerica	1	
	Brookline	1	
	Framingham	1	
	Maynard	1	
	Melrose	1	
	Milton	1	
	Natick	1	
	Saugus	1	
	Somerville	1	
	Watertown	1	
GRAND TOTAL		73	100

important step has been made. In relation to this, Dr. Ralph Truitt states:

> "The work of the Child Guidance Clinic is slow and its development remains in the hands of the community as a whole. .... Its life depends upon its assimilation into the organized communities. .... To be effectual, the clinic must establish functional connections with such agencies as the schools, the churches, case working societies, courts and institutions which deal with a thousand children to its one."[2]

It can be seen that at times, in reference to one case, the clinic staff may have to contact several agencies or persons within an area which heretofore had not been familiar with the clinic. Therefore the clinic, in each new contact, is fulfilling to a greater extent its scope of service to the community as stated previously.

The indication from Table IV is that the West End Clinic serves a great many locales outside the city of Boston, despite the fact that it is located in the city.

Sources of Referral

In order to consider further the inter-relationship of the clinic and the community, it is of interest to analyze what the source of referral was in each case. An investigation of this sort should indicate the extent to which the community is aware of the clinic's services and,

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more specifically, what agencies or individuals within the community make use of the clinic's function.

From the following table we see that the two general sources of referral are "Agency" and "Personal." "Agency" refers to all applications made through other community agencies; "Personal" includes all referrals made through known or indeterminate persons.

Of the forty-eight referrals included in the former category, nineteen were from the School Department, sixteen from Health Agencies, and thirteen from Social Agencies. The thirteen referrals from Social Agencies include five from private Children's Agencies, five from public Children's Agencies, two from family agencies, and one from the Department of Public Welfare. The largest percentage of Agency referrals came from the School Department. This is in keeping with trends of previous years.

The bulk of the school referrals seem to involve difficulties in school work and speech. The Health Agencies refer a large proportion of the Personality and Behavior cases. The Children's Agencies refer a majority of the cases in which diagnostic service in reference to mental capacity is requested. The remaining agencies referred behavior and retardation cases.

TABLE V

SOURCES OF REFERRALS OF NEW CASES

AT WEST END CLINIC

DURING FISCAL YEAR 1946

Sources		No.		%
1. Agencies and Institutions (Total)		48		65.75
a. Schools		19		26.03
b. Health Agencies		16		21.91
c. Social Agencies (Total)		13		17.81
1. Children's				
Private	5		6.85	
Public	5		6.85	
2. Other				
Private	2		2.74	
Public	1		1.37	
2. Personal (Total)		25		34.25
a. Referral by mother				
1. Familiarity with clinic through educational talks		3		4.11
2. Familiarity with clinic through previous clinic contact		5		6.85
b. Referral by parents of clinic patients		7		9.59
c. Referral by friends and relatives (Other than parents of clinic patients)		3		4.11
d. Referral by physicians		7		9.59
GRAND TOTAL		73		100.00

TABLE V

SOURCES OF REFERRALS OF NEW CASES

AT WEST SIDE CLINIC

DURING FISCAL YEAR 1946

Source	No.	%
1. Agencies and Institutions (Total)	46	63.7%
a. Schools	19	26.03
b. Health Agencies	16	21.91
c. Social Agencies (Total)	13	17.81
1. Children's		
Private	3	0.85
Public	5	6.85
2. Other		
Private	2	2.74
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b. Referral by parents of clinic patients	7	9.59
c. Referral by friends and relatives (Other than parents of clinic patients)	3	4.11
d. Referral by physicians	7	9.59
GRAND TOTAL	73	100.00

It is of importance to note that 34.25% of the referrals were "personal" in origin. Referrals of this type have been increasing through the years. From the significant proportion of these personal referrals it would seem that the West End Child Guidance Clinic has a recognized and accepted place in the community and that the value of its services and functions are gaining increased recognition among the lay, as well as professional, groups.

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CHAPTER V

THE CLINIC PATIENTS

THEIR BACKGROUNDS, THEIR PROBLEMS

The Children

Who are the children which the West End Clinic serves? How old are they? Why were they referred? What are their backgrounds? What possible factors lie behind their need for the clinic's services? These and many similar questions present themselves and, in attempting an answer, an analysis of the nature of the clinic clientele will be made.

It should be remembered that this study is limited by the comparatively small number of cases and, therefore, it precludes the formation of any definite conclusions. It is hoped, however, that an investigation into the problems will give indications of areas wherein the clinic is of service.

a. Distribution of Age and Sex and Ideal School Placement Among the Cases Referred

The graphic presentation of the children according to their age and sex indicates that of the seventy-three new cases opened during 1946, forty-eight, or 65.75% were boys and only twenty-five, or 34.25% were girls. This is in keeping with trends of previous years and in most

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TABLE VI

AGES AND SEXES OF CASES OPENED DURING 1946

GROUPED ACCORDING TO SCHOOL PLACE-

MENT IN TERMS OF CHRONOLOGICAL AGE

School Placement	Pre-School						Elementary School						Junior H. S.			Totals	
Age	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	No.	%
Boys	0	0	3	0	7	6	9	8	4	0	4	1	2	2	2	48	68.75
Girls	0	0	2	2	1	3	4	1	2	1	2	3	0	3	1	25	34.25
Total of both sexes combined	0	0	5	2	8	9	13	9	6	1	6	4	2	5	3	73	100.00
GRAND TOTALS of Both Sexes Combined	5				19		28				11			10			
GRAND TOTALS of Both Sexes in per cent	6.85				26.03		38.36				15.07			13.70			100.00

TABLE VI

AGES AND SEXES OF CASES ORDERED DURING 1946

CLASSIFIED ACCORDING TO SCHOOL PLACE-

MENT IN TERMS OF CHRONOLOGICAL AGE

School Placement	Pre-School		Elementary School										Junior H. S.		Totals	
Age	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	No.	%
Boys	0	0	3	0	7	6	9	8	4	6	4	1	2	3	2	48	68.76
Girls	0	0	2	2	1	3	4	1	2	1	2	3	0	3	1	25	34.25
Total of both sexes combined	0	0	5	2	8	9	13	9	6	1	6	4	2	6	3	73	100.00
GRAND TOTALS of Both Sexes Combined			5			19			28			11			10		
GRAND TOTALS of Both Sexes in per cent			6.85			26.03			38.36			15.07			13.70		100.00

Child Guidance clinics. One tentative explanation for this is that the tendency for boys to act out their difficulties in an aggressive manner results in early recognition of a need for assistance. Another explanation is the belief by some that, since boys are apt to show their difficulties earlier than girls[1], the age range at clinic would naturally favor male referrals. This is borne out to some degree in the above table.

In considering the distribution of age without regard to sex, it is indicated that the bulk of the referrals come from the school age group.

This may be partially explained by the fact that parents do not regard the problems of the younger child as serious enough to warrant aid from an outside source. The well-known remark "He will grow out of it" is indicative of this attitude. With the child's entrance to school, however, the problem may become intensified. Also, the teacher may call the parent's attention to the problem and sufficient alarm about it is produced to bring about a referral.

In reference to the bearing which school has upon referrals, from Table VI it can be seen that in both sexes there is a heavy cluster of referrals about the ages at which a child is experiencing his first years at school. It may be conjectured from this that adapting to the school

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situation brings to the fore many of the problems and difficulties which lay sequestered in the background during the years when the child lived in a more protected environment.

b. Range of Intelligence

TABLE VII

DISTRIBUTION OF INTELLIGENCE AMONG NEW CASES SERVED BY WEST END CLINIC DURING FISCAL YEAR 1946

Intellectual Capacity	No. of Cases	%
Mentally Deficient (69 and below)	5	6.85
Borderline (70-79)	10	13.70
Dull Normal (80-89)	14	19.18
Average (90-99)	20	27.40
Average (100-109)	13	17.81
Superior (110-119)	5	6.85
Very Superior (120-129)	3	4.11
Exceptional (130 and above)	3	4.11
TOTAL	73	100.01

situation brings to the fore many of the problems and difficulties which lay sequestered in the background during the years when the child lived in a more protected environment.

b. Range of Intelligence

In compiling the range of intelligence found in clinic referrals, forty-four cases or 60.28% of the seventy-three new cases studied were of average or above average intelligence; fourteen or 19.18% of the total group had dull normal ratings; ten cases or 14% were of borderline intelligence; and only five referrals were found to be mentally deficient.

If in this study, the dull normal group were to be considered as within normal, the percentage of new cases taken on at clinic for the time studied would be 79.45%.[2]

In classifying the extent and type of service rendered in terms of the intelligence of the patient, it was found that in the cases in which the patient's intelligence was not in the "normal or above normal class" the clinic's service was a diagnostic one. For the most part, treatment service was rendered to the normal and above normal group whose intellectual capacities would render them able to make the best use of the clinic's resources. It might be well to add that the clinic has no stated policy about

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c. Problems

Grouping the various problems under the headings used was found to be a difficult task, as many of the children could be classified into more than one group. In order to circumvent this, the classifications were made in accordance with the problem which the informant at intake stressed as being the most disturbing.

The categorical terms used in Table VIII include:

1. Personality and habit disturbances which refers to:

a. Personality and behavior disturbances involving fearful or aggressive behavior, and

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b. Habit disturbances which are those involving unaccepted patterns in reference to basic biological needs, i.e., feeding, enuresis, masturbation, etc.

2. Speech - which refers to difficulty in pronouncing words or speaking smoothly and easily.

3. School work - which refers to inability to do the quality of work expected of the average student in the grade placement.

4. Question of mental capacity, which refers to requests precipitated by the child's slow development, or by doubt about his intellectual ability.

TABLE VIII

FREQUENCY OF REFERRAL

GROUPED ACCORDING TO PROBLEM AND SEX

Reason for Referral	Males Referred	Females Referred	Total
Personality and Behavior	26	11	37
Speech	12	6	18
School Work	7	2	9
Question of establishing mental ability	3	6	9
Total	48	25	73

Reason for Referral	Males Referred	Females Referred	Total
Personality and Behavior	28	11	37
Speech	12	6	18
School Work	7	2	9
Question of establishing mental ability	3	6	9
Total	48	25	73

TABLE IX

PROPORTION OF FREQUENCY OF

REFERRAL FOR EACH SEX

Reason for Referral	Sex			
	Male		Female	
	No.	%	No.	%
Personality and Behavior	25	54.17	11	44.00
Speech	12	25.00	6	24.00
School Work	7	14.58	2	8.00
Question of establishing mental ability	3	6.25	6	24.00
Total	48	100.00	25	100.00

Table VIII indicates that the greatest number of referrals for both sexes involve personality and behavior difficulties. Twenty-six of the total boys referred, or 54.17% were referred for the above stated reasons; eleven of the twenty-five girls referred, or 44% of the total female patients were referred for similar reasons. However, the investigator noticed that the specific problem for which the boys were referred generally involved aggressive behavior, whereas the greatest bulk of the personality and behavior referral problems for which the girls were referred involved habit disturbances such as masturbation and enuresis. It might be said that boys in general tend

TABLE IX

PROPORTION OF FREQUENCY OF

REFERRAL FOR EACH SEX

Reason for Referral	Sex			
	Male		Female	
	No.	%	No.	%
Personality and Behavior	28	64.17	11	44.00
Speech	12	28.00	6	24.00
School Work	7	14.28	2	8.00
Question of establishing mental ability	3	6.28	6	24.00
Total	48	100.00	25	100.00

Table VIII indicates that the greatest number of referrals for both sexes involve personality and behavior difficulties. Twenty-six of the total boys referred, or 64.17% were referred for the above stated reasons; eleven of the twenty-five girls referred, or 44% of the total female patients were referred for similar reasons. However, the investigator noticed that the specific problem for which the boys were referred generally involved aggressive behavior, whereas the greatest bulk of the personality and behavior referral problems for which the girls were referred involved habit disturbances such as masturbation and enuresis. It might be said that boys in general tend

to use more aggressive means - means which affect the social group - for expressing their difficulties, whereas the girls seek more personally focused outlets of expression.

The second greatest referral request for both sexes involved speech difficulty. In each sex, speech referrals amounted to about 25% of the total referrals.

The third highest reason for referral was that of poor school work. In this category, 14.58% of the total males referred were referred because of a complaint about school; however, only 8% of the total females referred were brought to clinic because of school work problems.

The least number of referrals for both sexes individually and for the sexes combined involved referral requests for determining mental ability. This fact is borne out further in statistics and statements presented in Chapter III. The higher percentage of girls referred for this reason is explained by the fact that these referrals were referrals preparatory to adoption. It has been found that adoptive parents generally prefer females, feeling they are less difficult to rear and will remain with the family longer. Usually in these cases, only diagnostic service is desired and, for the most part, the clinic is more widely known and used for its treatment services.

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Family Backgrounds of the Children

a. Religion and Race

TABLE X

NEW CASES OPENED DURING 1946

GROUPED ACCORDING TO RELIGION AND COLOR

	Religion						
	Catholic		Protestant		Hebrew		Grand
Race	No.	%	No.	%	No.	%	Total
White	35	47.95	18	24.66	18	24.66	
Negro	1	1.37	1	1.37	0	0	
Total No.	36		19		18		73
Total %		49.32		26.03		24.66	100.01

In the above table, the distribution of religion and color among the new cases opened during the period studied, is indicated. It is interesting to note that the religious distribution does not follow to any great degree the rough estimates available on the proportionate religious applications among the population of Greater Boston.[4] This does not necessarily indicate that there is a tendency of any

4 Available statistics obtained from Boston Council of Churches for proportionate distribution of religion among the Boston - Greater Boston Area indicates that 70% of the population are Catholic; 20% are Protestant; and 10% are Hebrew.

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GROUPED ACCORDING TO RELIGION AND COLOR

	Religion						
	Catholic		Protestant		Hebrew		Grand
Race	No.	%	No.	%	No.	%	Total
White	55	67.98	18	24.66	18	24.66	
Negro	1	1.37	1	1.37	0	0	
Total No.	56		19		18		73
Total %	49.32		26.03		24.66		100.01

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[4] Available statistics obtained from Boston Council of Churches for proportionate distribution of religion among the Boston - Greater Boston Area indicates that 70% of the population are Catholic; 20% are Protestant; and 10% are Hebrew.

one religion to produce a greater number of children with difficulties. It has been felt, however, that the various religions seem to produce problems peculiar to each of them. The disproportionate number of Hebrew referrals may be partially explained by the fact that these referrals came from a small number of specifically Jewish communities in which local agencies have for a long time been familiar with and using the clinic's services and facilities. Another interesting positive correlation is the high proportion of Hebrew males referred. The cultural pattern among Jewish families has indicated that the male child in the family receives greater attention and is of greater importance than the female. This fact may contribute to:

1. The predominance of male patients.
2. The relatively high number of Hebrew patients.

The unrepresentativeness of the proportion of Catholic referrals in relation to the ratio of their numbers in the general population of the Boston Area may be partially explained by the role which the Church plays in the Catholic family's life.

The small number of Negro referrals does not indicate that the children of this race are less susceptible to difficulties. In fact, it is realized that, though the social and economic status of negroes tends to produce

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The small number of Negro referrals does not indicate that the children of this race are less susceptible to difficulties. In fact, it is realized that, though the social and economic status of negroes tends to produce

many and complicated problems among their members, the same factors which produce the difficulties hamper the individuals from having the ability or time to spare to use the clinic's facilities. In addition, Table X reveals that though the proportion of negro clinic patients is less than the proportion of negroes in the Boston Area, it is not significantly less.

b. Economic Status

For the purpose of classifying Economic Status of the families from which the seventy-three cases come, certain descriptive terms were used. The term "comfortable" means that the family has enough funds to maintain itself adequately and that there is no immediate threat to its present economic situation. "Marginal" means that the family is maintaining itself independent of any aid from any outside source, but the income provides only the bare necessities of life. "Dependent" means that the family is receiving partial or complete financial assistance from a public or private source outside the family.

TABLE XI

ECONOMIC STATUS IN FAMILIES OF CASES OPENED DURING 1946

Economic Status	No.of Cases	%
Comfortable	51	69.86
Marginal	17	23.89
Dependent	5	6.85
Total	73	100.00

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TABLE XI

ECONOMIC STATUS IN FAMILIES OF CASES SEEKED DURING 1946

Economic Status	No. of Cases	%
Comfortable	51	69.86
Marginal	17	23.29
Dependent	5	6.85
Total	73	100.00

Table XI indicates that fifty-one of the seventy-three cases opened, or 69.86% of them came from families whose incomes provided adequately for the needs of the patients. Only seventeen, or 23.89% of the total number, came from homes which have a "marginal" income, and the remaining five cases, or 6.85%, were dependent to some extent upon outside sources for their maintenance.[5] These figures indicate that a majority of the clinic's patients come from "comfortable" homes. The finding of this table suggests:

1. That poverty does not necessarily produce difficulties in children.

2. That the families in the lower income brackets, being engrossed in maintaining themselves, have not been making full use of the clinic's facilities.

To pursue the question of the bearing of economic status upon children and their difficulties, Table XII has been compiled.

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5 It should be recognized that 1946 was a fairly prosperous year and that this may account in some measure for the small number of referrals of patients from the lower income brackets.

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To pursue the question of the bearing of economic status upon children and their difficulties, Table XII has been compiled.

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5 It should be recognized that 1930 was a fairly prosperous year and that this may account in some measure for the small number of referrals of patients from the lower income brackets.

TABLE XII

FREQUENCY OF REFERRAL REQUEST GROUPED ACCORDING TO ECONOMIC STATUS OF PATIENTS REFERRED DURING FISCAL YEAR 1946

Reason for Referral	Economic Status					
	Comfortable		Marginal		Dependent	
	No.	%	No.	%	No.	%
Personality and Behavior	24	47.06	10	58.82	3	60.00
Speech	13	25.49	4	23.53	1	20.00
Question of Establishing Mental Capacity	6	11.76	2	11.77	1	20.00
Poor School Work	8	15.69	1	5.88	0	0
Total in Number	51		17		5	
Total in Per cent		100.00		100.00		100.00

The results of this table indicate that economic status has no bearing upon the proportionate distribution of reasons for referral among the new cases at the clinic during 1946. The percentage of the four reasons for referral are almost the same in each of the three economic brackets. It may be noted, however, that the frequency of referrals for poor school work increases as the economic level improves. This may be due to the higher standards of achievement expected among the higher income brackets. Also, as stated before, families who are struggling to survive are not free

TABLE XII

FREQUENCY OF REFERRAL REQUEST CHOSEN ACCORDING TO ECONOMIC STATUS OF PATIENTS REFERRED DURING FISCAL YEAR 1946

Reason for Referral	Economic Status: Comfortable No.	%	Marginal No.	%	Dependent No.	%
Personality and Behavior	24	47.06	10	58.82	3	60.00
Speech	13	25.49	4	23.53	1	20.00
Question of Establishing Mental Capacity	6	11.76	2	11.77	1	20.00
Poor School Work	8	15.69	1	5.88	0	0
Total in Number	51		17		5	
Total in Per cent		100.00		100.00		100.00

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enough to observe and attend to their children's needs and disturbances.

c. Marital Status in the Home

In other areas of work with children[6], much has been written about the influence which marital status of the parents in the home have upon the child's development and adjustment to life. In Table XIII below, the author has endeavored to determine whether the clinic patients referred during 1946 came from broken homes or average homes, and also to see whether the distribution of referral requests vary with the home environment.

In this table, "broken home" refers to a family group wherein one parent is absent. "Average home" refers to a family group in which there are two parents living in the home.

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6 Juvenile Delinquency and Institutional Work with Children.

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In this table, "broken home" refers to a family group wherein one parent is absent. "Average home" refers to a family group in which there are two parents living in the home.

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6 Juvenile Delinquency and Institutional Work with Children.

TABLE XIII

CASES OPENED DURING 1946 GROUPED ACCORDING TO HOME ENVIRONMENT AND REASON FOR REFERRAL

Home Environment	Broken Home		Average Home	
Reason for Referral	No. of Patients	%	No. of Patients	%
Total	10	100.00	63	100.00
Personality and Behavior	6	60.00	31	49.20
Speech	2	20.00	16	25.40
Question of Establishing Mental Ability	1	10.00	8	12.70
Poor School Work	1	10.00	8	12.70

Statistical analysis of the marital status in the family from which new patients came during 1946, indicates that sixty-three of the seventy-three cases referred, or 86.30% of the total came from homes in which there are two parents present, whereas only ten cases, or 13.70% of the total came from "broken homes." The distribution of the four referral requests does not vary significantly between the two categories[7], however, although referrals for Personality and Behavior difficulties are proportionately somewhat higher among the cases who come from broken homes than those who come from average homes.

7 The small number of total "broken home" referrals diminishes to a great extent the possible value of the inferences drawn from the results.

TABLE XIII

CASES OPENED DURING 1946 GROUPED ACCORDING TO HOME ENVIRONMENT AND REASON FOR REFERRAL

Reason for Referral	Broken Home: No. of Patients	Broken Home: %	Average Home: No. of Patients	Average Home: %
Total	10	100.00	63	100.00
Personality and Behavior	6	60.00	31	49.20
Speech	2	20.00	16	25.40
Question of Establishing Mental Ability	1	10.00	8	12.70
Poor School Work	1	10.00	8	12.70

Statistical analysis of the marital status in the family from which new patients came during 1946, indicates that sixty-three of the seventy-three cases referred, or 86.30% of the total came from homes in which there are two parents present, whereas only ten cases, or 13.70% of the total came from "broken homes." The distribution of the four referral requests does not vary significantly between the two categories[7]. However, although referrals for Personality and Behavior difficulties are proportionately somewhat higher among the cases who come from broken homes than those who come from average homes.

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Size of Family and Ordinal Position Within the Family

TABLE XIV

CASES OPENED DURING 1946 GROUPED ACCORDING TO ORDINAL POSITION IN AND NUMBER OF CHILDREN IN FAMILY

Ordinal Position	Number of Children in Family								Total No.	% of Total Cases
	1	2	3	4	5	6	7	8		
Only	12	-	-	-	-	-	-	-	12	16.44
Youngest	-	12	5	1	0	-	1	-	19	26.03
Middle	-	-	11	1	4	1	2	2	21	28.77
Oldest	-	10	7	2	2	-	-	-	21	28.77
Total	12	22	23	4	6	1	3	2	73	100.01
Total in %	16.44	30.14	31.51	5.48	8.22	1.37	4.11	2.74		100.01

From the above table it can be seen that the greatest number of the new cases opened during 1946 came from families in which there were two or three children; 61.51% of the total number of cases studied fell within this group. It is of interest to note that the number of referrals of "youngest" children, "middle" children and "oldest" children in the family is quite equally divided among the group. There appears to be less referrals of "only" children.

Size of Family and Ordinal Position Within the Family

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CASES OPENED DURING 1946 CLASSED ACCORDING TO ORDINAL POSITION IN AND NUMBER OF CHILDREN IN FAMILY

Ordinal Position	Number of Children in Family								Total No. Cases	Total % of Total
	1	2	3	4	5	6	7	8		
Only	12	-	-	-	-	-	-	-	12	16.44
Youngest	-	12	5	1	0	-	1	-	19	26.03
Middle	-	-	11	1	4	1	2	2	21	28.77
Oldest	-	10	7	2	2	-	-	-	21	28.77
Total	12	22	23	4	6	1	3	2	73	100.01
Total in %	16.44	30.14	31.51	5.48	8.22	1.37	4.11	2.74		100.01

From the above table it can be seen that the greatest number of the new cases opened during 1946 came from families in which there were two or three children; 81.81% of the total number of cases studied fell within this group. It is of interest to note that the number of referrals of "youngest" children, "middle" children and "oldest" children in the family is quite equally divided among the group. There appears to be less referrals of "only" children.

These results seem to indicate that ordinal position, though it may produce symptoms peculiar to the position, does not have any particular bearing upon a child's possible need for Child Guidance services.

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CHAPTER VI

CASE ILLUSTRATIONS

The preceding chapters have indicated that the program of service in the Child Guidance is varied and flexible and lends itself to meet a diversity of situations and problems. The clinic applies any and all of its services according to the needs of the individual case in the belief that those used will be of greater value to the child in question and, in the long run, to the most economical and efficient use of the clinic's resources. Figure I, following, illustrates the procedure.

By presenting three case illustrations; two cases involving treatment and the other diagnostic service; it is hoped that a greater understanding of the actual functioning of the clinic will be obtained.

a. Case Illustrations

1. A Case Involving Psychiatric Treatment

This was a situation in which the mother brought the patient to clinic after learning about the services through a talk given by one of the social workers at a Parent-Teachers' Association Meeting.

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FIGURE I

OUTLINE OF TYPICAL INTAKE AND SERVICE PROCEDURE AT THE WEST END CLINIC

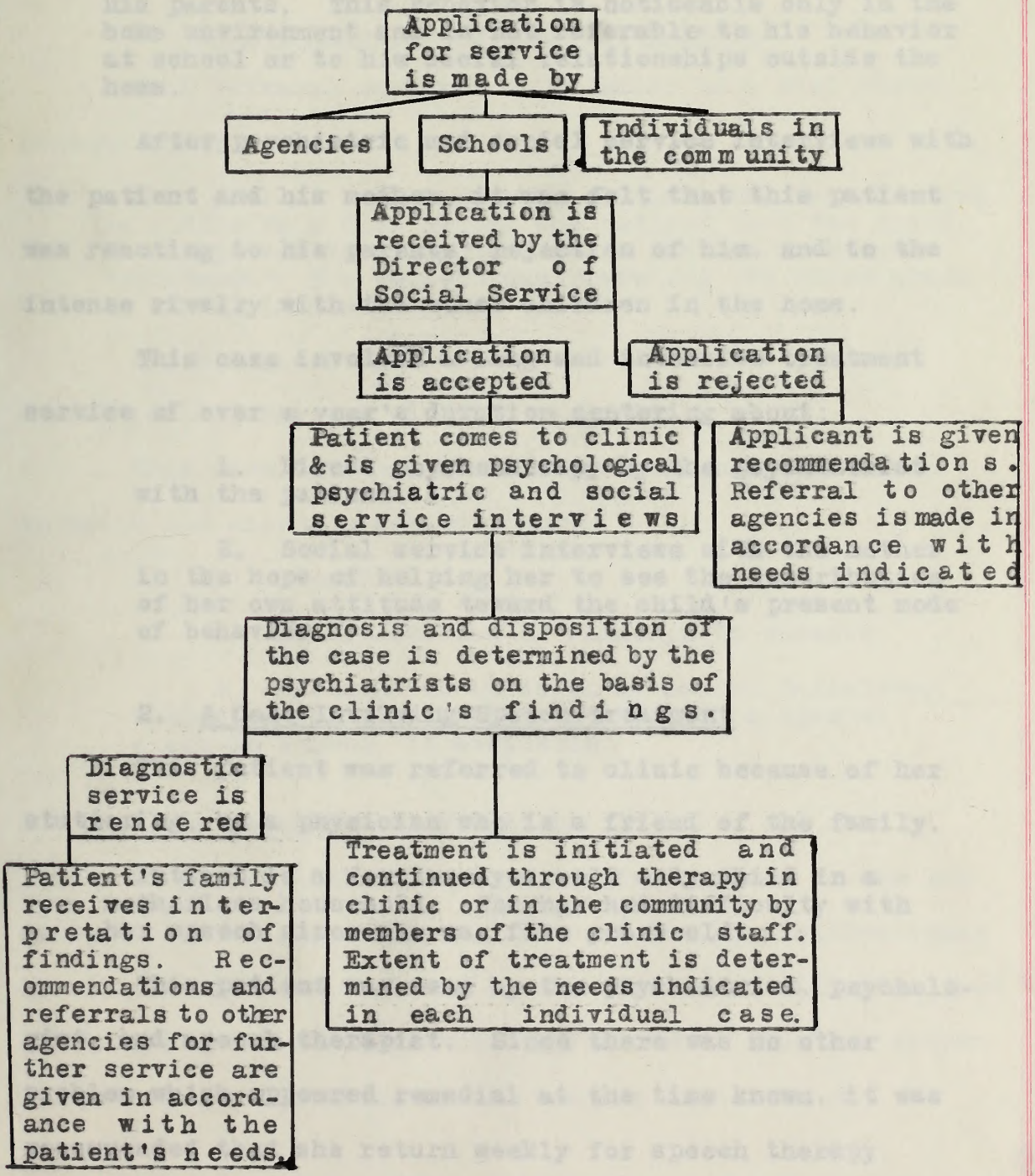

FIGURE I

OUTLINE OF TYPICAL INTAKE AND SERVICE

PROCEDURE AT THE WEST END CLINIC

This patient is an eight-year-old well-built Jewish boy of a "comfortable" middle-class family who live in a nearby city. The patient is described by his mother as being a "bad boy" at home. He cannot get along with his older sister and three younger brothers; he is destructive in the home and is disrespectful to his parents. This behavior is noticeable only in the home environment and is not referable to his behavior at school or to his social relationships outside the home.

After psychiatric and social service interviews with the patient and his mother, it was felt that this patient was reacting to his parents' rejection of him, and to the intense rivalry with the other children in the home.

This case involved a long and intensive treatment service of over a year's duration centering about:

1. Direct psychotherapy by the psychiatrist with the patient.

2. Social service interviews with the mother in the hope of helping her to see the contribution of her own attitude toward the child's present mode of behavior.

2. A Case Involving Speech Treatment

This patient was referred to clinic because of her stuttering, by a physician who is a friend of the family.

Patient is a fourteen-year-old only child in a motherless household. She has had difficulty with her speech since she was five years old.

This patient was seen by the psychiatrist, psychologist, and speech therapist. Since there was no other problem which appeared remedial at the time known, it was recommended that she return weekly for speech therapy.

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This patient was referred to clinic because of her stuttering, by a physician who is a friend of the family.

Patient is a four teen-year-old only child in a motherless household. She has had difficulty with her speech since she was five years old.

This patient was seen by the psychiatrist, psychologist, and speech therapist. Since there was no other problem which appeared remedial at the time known, it was recommended that she return weekly for speech therapy.

Social Service contact with the father is maintained from time to time, but the primary focus is upon speech retraining.

3. A Case Involving Diagnostic Service

This referral was made by a leader of a Girl Scout Brownie Group.

> This patient is a nine-year-old girl who was referred to clinic by a Club Leader who noticed that the child, in comparison to other members in the group, seemed "backward." The patient was repeating the third grade in school (parochial).

Psychological tests administered to this patient indicated that she was mentally retarded.

This case involved a short-term diagnostic service in which the clinic's activity was:

1. Diagnosis.
2. Interpretation of findings to parents.
3. Referral to Division of Mental Deficiency with recommendations for placement in a special class in school, if available.

b. Comments About Agency Function

In each of the three illustrations given, we see the manner in which referrals are made and how application comes about. We also see that the agency offered an individualized consultation and adjustment to the patient. This was accomplished by a combination of the methods listed below:

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1. Direct interviews (psychological, social service, and psychiatric) with the patient and important personages in his home environment for purposes of evaluation.

2. Evaluation of the whole problem, first in terms of the total situation and then in terms of its adaptability to treatment methods offered by the clinic.

3. Referral to the proper community resource in an instance when it was felt that the immediate needs of the patient might be more adequately met by another agency.

4. Treatment interviews (psychiatric and/or social service) with the patient and/or members of his family in order to reduce internal and external pressures.

5. Use of speech therapy facilities of the clinic where a need for specialized speech treatment is necessary.

As indicated by the cases, the extent and intensity of services is gauged to meet the need of the patient as understood after a profile of the patient's assets, liabilities, and total situation has been compiled.

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In the first case, intensive psychiatric and social service treatment was prescribed for the patient and his mother.

In the second case, where the speech difficulty was the only problem revealed which was remedial at the time, focus was directed almost entirely upon this area. Social Service contact with the father was maintained in order to have an understanding of the child and her whole situation all during treatment.

In the third case, where the extent of service was limited to diagnosis and referral, the clinic can be seen utilizing another resource to complement its own functions, and to give the patient an opportunity to receive adequate service from an agency equipped to render the service needed.

In conclusion, the combined technical skills of the clinic staff offer highly refined diagnostic and treatment tools whereby the clinic is able to dispense appropriate individualized services to the patient and ultimately to the community.

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CHAPTER VII

SUMMARY AND CONCLUSIONS

The Child Guidance Movement developed as a result of the converging of two other movements - Mental Hygiene and the Prevention of Juvenile Delinquency. In its formative years, the focus of Child Guidance shifted from interest in the child whose behavior had precipitated his court appearance, to the child whose behavior manifestations had not brought him to court. With this shift of interest, the Child Guidance Clinic began to operate in co-operation with schools and health and social agencies in the community rather than with the court. Thus it is now related to all agencies in the community which are concerned with the welfare of children.

State supervised Child Guidance Programs came into existence in the 1920's. Massachusetts was the first state to organize this type of service to its populace. The West End Child Guidance Clinic was one of the first of these clinics.

In order to understand the extent to which the clinic serves the community, it is well to note the areas it serves.

Of the new patients who were accepted for service during 1946, forty-two per cent came from the Corporate

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City of Boston, whereas fifty-eight per cent came from cities and towns in the Greater Boston area. In connection with the latter percentage, nineteen locales in the Metropolitan Boston area were served. This indicates that the clinic's service is distributed liberally over a wide area and that, despite the fact that it is situated in the city, it continues to widen the areas of contacts which fall within its scope.

In analyzing further the inter-relationship of the clinic to the community and, in attempting to determine the clinic's status in the community, the sources of referral were examined. It was found that Agency and Institution made sixty-five per cent of the total referrals and that the thirty-four per cent remaining were referrals made by individual persons, both lay and professional, in the community. Of the Agency and Institution referrals, twenty-six per cent were made by health agencies, and about eighteen per cent were made by social agencies. The total proportion of personal referrals was higher than the proportion of school referrals, health agency referrals, of social agency referrals taken individually. It would seem from this that the services of the Child Guidance Clinic are receiving as much recognition and appreciation of worth from individuals as from agencies and institutions in the community. This has been a goal which Child Guidance

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enthusiasts have long been attempting to reach. It is felt that the family is closest to the child and, in order to treat a problem in its earliest stages, recognition of the problem and application for referral should be made by the family. The high proportion of personal referrals indicates that individuals are losing their self-consciousness about the difficulties of their children and are beginning to see Child Guidance in its preventive, as well as curative, role.

In attempting to study the nature of the clientele served by the clinic, several interesting factors were brought to light.

During 1946, referrals of boys to clinic amounted to sixty-six per cent of the total percentage referred. Referrals of children of both sexes are greater in frequency during the early school years. The distribution of proportional frequency of referral for each of the clinic's referral categories was approximately the same for both sexes. Personality and behavior referrals ranked highest, with speech, poor school work and question of establishing mental ability following successively. Fifty-four per cent of the boys and forty-four per cent of the girls were referred because of personality and behavior difficulties; twenty-five per cent of the total boys and twenty-four per cent of the total girls referred applied because of

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speech difficulties; fifteen per cent of the total boys' and eight per cent of the total girls' referrals involved complaints about poor school work. In regard to requests for establishing mental ability, six per cent of all the boys referred and twenty-four per cent of the total girls referred were brought to clinic for this service.

In studying the range of intelligence of the new cases accepted by the clinic during 1946, it was found that sixty per cent of the total accepted were of average or above average intelligence; (if the dull-normal group were to be considered as being "low average" the percentage would be seventy-nine per cent); fourteen per cent were found to be of borderline intelligence; and seven per cent of the total were found to be mentally deficient.

In surveying the backgrounds of the patients accepted during the period in question, it was found that the majority of them came from homes of comfortable means and from homes in which both parents were present. The majority of the patients came from homes in which there were two or three children in the family. The proportion of frequency of referral according to youngest, middle and oldest was almost equally distributed. There appeared to be fewer referrals of "only" children.

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In the total number of cases studied, it was found that the services rendered by the clinic were of two general types - diagnostic and treatment. Diagnostic service was rendered in those cases where it was felt that the clinic's service could not be applied most effectively. In these cases, recommendations to responsible persons and/or referrals to agencies more adequately equipped to meet the patient's needs, were made. Treatment service, the extent and type gauged to meet the needs presented by the patient and his problem, was offered in most instances.

In general, this study has brought out that the clinic handles a diversity of requests ranging from habit and personality disorders, speech, poor school work, to determining mental ability. The clinic receives referrals which involve deep-seated personality and habit problems and consequently some type of therapeutic treatment; it also receives referrals in which verification of the intellectual and emotional stability of the child is necessary in order to determine the child's needs. The clinic therefore is operating within its stated structure by serving the community in a diagnostic as well as treatment role.

Implications found by surveying the sources of referrals, the locales served, and the backgrounds of the clinic patients, are that the West End Clinic function is being

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Implications found by surveying the sources of referrals, the locales served, and the backgrounds of the clinic patients, are that the West End Clinic function is being

utilized wisely by professional and lay individuals as well as by organized agencies and institutions in the community.

The service of the clinic permeates many locales surrounding Boston.

The backgrounds of the children served indicate that, generally, the clinic is serving the normal child in a home of comfortable means in the average family constellation. This infers that the clinic is being used intelligently by parents and agencies who realize that the child in the average home may need the services of a Child Guidance clinic. This further indicates that the clinic is not regarded as a place of last resort but as a valuable source which offers preventive service.

In conclusion, the West End Child Guidance Clinic appears to be operating in complete accordance with the philosophy and tenets of present-day child guidance.

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APPENDIX

OUTLINE FOR SCHEDULE

I The Patient

Case No. Reason for Referral Date Referred Source of Referral

1. Age
2. Sex
3. Color
4. Religion
5. I.Q.
6. School Placement
7. Ordinal Position in Family
8. Name of Community

II The Family

1. Marital Status of Parents
2. Economic Status of Family
3. Occupation of Father
4. Number of Children in the Family
5. Ordinal Position of Children in Family

III Condition of Case at End of Fiscal Year

1. Open or Closed
2. Service Rendered
   a. Diagnostic or Treatment
3. If Treatment and Closed, Condition at Time of Closing
   a. Improved
   b. Unimproved
   c. Unknown

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